HEALTH OFFICE
400 MAIN STREET
DENVILLE, NJ 07834-2592
TEL. (973) 627-4600 X241
FAX (973) 784-6650

Dear Parents/Guardian(s) of ____

The health care forms submitted for your child indicate that she/he has a life-threatening anaphylactic allergy.

In order to be prepared to respond to an anaphylactic emergency, the school requires the following information to be submitted to the Health Office by the start of school in September:

1. Food Allergy & Anaphylaxis Emergency Care Plan (needs physician signature).

2. Authorization for Self-Administration Form (needs physician signature).

   These forms must be dated on or after July 1, for the applicable year.

3. A small picture of your child

4. Signed Emergency Health Plan.

5. Two epinephrine auto –injector's. One auto injector will remain in the health office and placement of the second auto injector will be in your child's backpack.

6. ***MOST IMPORTANT-YOU MUST ADVISE THE TRANSPORTATION DEPARTMENT OF YOUR HOME SCHOOL DISTRICT THAT YOUR CHILD HAS ANAPHYLAXIS. IT IS THE RESPONSIBILITY OF YOUR HOME SCHOOL DISTRICT TO ADVISE YOUR CHILD'S BUS DRIVER THAT YOUR CHILD HAS ANAPHYLAXIS AND TO ARRANGE FOR YOUR CHILD'S BUS DRIVER TO RECEIVE ANAPHYLACTIC TRAINING.***

These forms are required EACH YEAR in order for your child to participate in school athletic program, school sponsored activities and class trips.

We welcome the opportunity to meet with you and your child to discuss any concerns you may have.

Sincerely,

Mrs. Ioannou, RN
Mrs. Quaglio, RN
School Nurses

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE Food Allergy Research & Education

PLACE PICTURE HERE

Name: ______________________ D.O.B.: __________

Allergy to: ______________________

Weight: __________ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: __________

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: __________

Antihistamine Dose: __________

Other (e.g., inhaler-bronchodilator if wheezing): __________

____

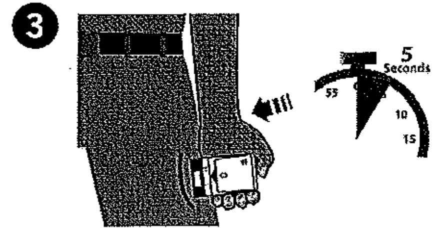
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

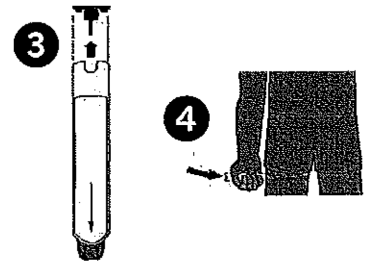
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



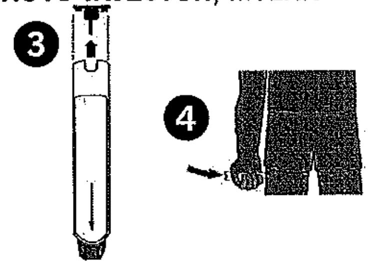
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



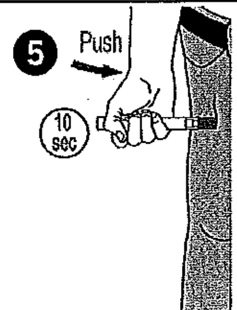
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________

DOCTOR: ______________________ PHONE: ____________

PARENT/GUARDIAN: ______________________ PHONE: ____________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

Morris County School of Technology Physician Certification for Self-Medication

EPINEPHRINE

N.J.S.A. 18A:40-12.3

NAME OF STUDENT ______________________________ GRADE __________

ACADEMY ______________________________

MEDICAL CONDITION ______________________________

MEDICATION/DOSAGE EPIPEN 0.3MG IM ______________________________

TIME TO BE ADMINISTERED ______________________________

POSSIBLE SIDE EFFECTS ______________________________

SCHOOL YEAR ______________________________

I certify that the aboved name student student suffers from the above medical condition which is a potentially life-threatening illness. I have discussed the administration of this medication with the above-named student; and I certify that he/she is capable of, and has been instructed in, the proper method of self-administration of the medication in an emergency situation as directed above.

______________________________ ______________________________

Physician's Signature Date

Physician's STAMP

____

Parent Acknowledgment and Authorization Pursuant to N.J.S.A. 18A:40-12.3

I hereby authorize my child to carry his/her medication during school, on field trips and during school-sponsored extracurricular activities. My child has been instructed on self-administration of the medication in potentially life threatening situations as evidenced by my submission of the above Physician Certification. I also understand that I am responsible for providing the medication and am responsible for replacing it if it has expired or been used.

By also signing the Acknowledgment, I understand that the Board of Education, its employees or agents shall incur no liability as a result of any injury arising from the self-administration or medication of the student; and I hereby indemnify and hold harmless the Board and its offices, employees and agents against any claims arising out of the self-administration of medication by the student.

This permission is effective the current school year only and will be reviewed each subsequent school year if the medication needs to be continued.

______________________________ ______________________________

Parent or Guardian Signature Date

I give permission for the school nurse to release my child's health concern as indicated above, to the staff at MCVTS. The school nurse may also indicated this health concern on the Genesis Program.

______________________________ ______________________________

Parent signature *Date*

Morris County School of Technology
Individual Health Care Plan for Anaphylaxis

STUDENT________________________________GRADE__________ACADEMY_______________

SCHOOL YEAR____________ FULL TIME ______ SHARE TIME_____ DELEGATE ________________

A. **ALLERGEN(S)** ____

B. **Brief History of Anaphylaxis:** ____________________________________

____

____

Indicate items that are components of student's Individual Health Care Plan (IHCP)

__X__ The student has been informed by the family and physician about foods/allergens to avoid.

_____ The student may not eat any foods during the school day except as provided by the home.

_____ The student needs to sit at a peanut free table.

__X__ The parent will review the lunch menu with the student if able purchase food.

_____ The student may not come in contact with the offending food(s)

_____Smell _____Feel _____Taste

_____ Cleaning of school furniture is required prior to student use if known food contamination has occurred. **NOTE:** The classroom teacher notifies the custodian of the need for cleaning furniture due to food contamination.

_____ Other____.

C. **Classroom School Routines and Activities**

The student's single dose epinephrine auto-injector and pre-measured uni-dose antihistamine will be located:

____Fanny Pack* _____Health Office _____Backpack

Having the auto-injector carried in a fanny pack on the student's person is the only option that assures availability of the epinephrine at all times.

The student who is authorized to self administer:

__X__ Will have a single dose epinephrine auto-injector and pre-measured uni-dose antihistamine, if ordered by medical provider, on his/her person at all times.

__X__ Student is aware that he/she must report immediately to the school nurse or teacher if he/she has a suspected exposure to allergens(s), any signs of allergic reaction, or has used medication.

__X__ **The parent will replace auto injectors and antihistamine/other medications upon expiration or usage. Expiration of Epi-pen: ________________.**

_______ The student is transported by school bus # _____.

_______ The student is transported by parents.

_______ The student walks/drives to school.

_______ Teacher will notify school nurse of all Field Trips.

__X__ If the parent/guardian does not want a volunteer delegate assigned to his/her student, the parent/guardian must submit in writing to the health office.

_______ Other____

D. Response to an episode

__X__ The adult in charge calls or designates another adult to call 911. The caller must specify that t student is experiencing anaphylaxis.

__X__ Simultaneously to the call to 911, epinephrine via a single dose auto-injector is administered by the school nurse, parent, or trained designee.

__X__ Follow- up is carried out by the appropriate personnel including transportation to the nearest hospital emergency room by emergency medical personnel.

_______ Other ____

E. Delegation

______Yes ____NO **I give permission for the school nurse to train delegates to administer my child's Epi-pen for anaphylaxis when the nurse is not physically present at the scene.**

I acknowledge that the district and its employees shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto injector mechanism, and shall hold harmless the district and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto injector mechanism to my child.

______________________	__________	______________________	__________
Parent/Guardian's Signature	Date	Parent/Guardian's Signature	Date

I authorize the school nurse to share my child's individual Health Care Plan for Anaphylaxis and Physician's Certification of Student's Potential for Anaphylaxis and Emergency Health Care Plan with the school staff, administration and PTA as needed. The school nurse may release this information electronically and post my child's Anaphylaxis concern on the Genesis Staff Portal.

______________________	__________	______________________	__________
Parent/Guardian's Signature	***Date***	***Parent/Guardian***	***Date***